COPY

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

CERTIFIED MAIL: 7007 0710 0002 7979 0888

December 3, 2010

Cliff McAleer, Administrator
Milestone Decisions Inc #1 Grant
611 South Main
Moscow, ID 83843

RE: Milestone Decisions Inc #1 Grant, Provider #13G016

Dear Mr. McAleer:

Based on the Medicaid/Licensure survey completed at Milestone Decisions Inc #1 Grant on November 18, 2010, we have determined that Milestone Decisions Inc #1 Grant is out of compliance with the Medicaid Intermediate Care Facility for Persons with Mental Retardation (ICF/MR) Condition of Participation on **Client Behavior & Facility Practices (42 CFR 483.450)**. To participate as a provider of services in the Medicaid program, an ICF/MR must meet all of the Conditions of Participation established by the Secretary of Health and Human Services.

The deficiencies which caused this Condition to be unmet, substantially limit the capacity of Milestone Decisions Inc #1 Grant to furnish services of an adequate level or quality. The deficiencies are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567). A similar form indicates State Licensure deficiencies.

You have an opportunity to make corrections of those deficiencies, which led to the finding of non-compliance with the Conditions of Participation referenced above by submitting a written Credible Allegation of Compliance/Plan of Correction.

It is important that your Credible Allegation/Plan of Correction address each deficiency in the following manner:

1. What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice;

2. How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;

3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;

4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,

5. Include dates when corrective action will be completed.

Sign and date the form(s) in the space provided at the bottom of the first page.

Such corrections must be achieved and compliance verified by this office, before January 2, 2011. To allow time for a revisit to verify corrections prior to that date, it is important that the completion dates on your Credible Allegation/Plan of Correction show compliance no later than December 25, 2010.

Please complete your Allegation of Compliance/Plans of Correction and submit to this office by **December 16, 2010**.

Failure to correct the deficiencies and achieve compliance will result in our recommending that the Medicaid Agency terminate your approval to participate in the Medicaid Program. If you fail to notify us, we will assume you have not corrected.

Also, pursuant to the provisions of IDAPA 16.03.11.320.04, Milestone Decisions Inc #1 Grant ICF/MR is being issued a Provisional Intermediate Care Facility for Persons with Mental Retardation license. The license is enclosed and is effective November 18, 2010, through March 18, 2011. The conditions of the Provisional License are as follows:

1. Post the provisional license.

2. Correct all cited deficiencies and maintain compliance.

Please be aware that failure to comply with the conditions of the provisional license may result in further action being taken against the facility's license pursuant to IDAPA 16.03.11.350.

Be advised, that, consistent with IDAPA 16.05.03.300, you are entitled to request an administrative review regarding the issuance of the provisional license. To be entitled to an administrative review, you must submit a written request by **December 29, 2010**. The request must state the grounds for the facility's contention of the issuance of the provisional license. You should include any documentation or additional evidence you wish to have reviewed as part of the administrative review.

Your written request for administrative review should be addressed to:

Randy May, Deputy Administrator
Division of Medicaid -- DHW
PO Box 83720
Boise, ID 83720-0036
Phone: (208)364-1804
Fax: (208)364-1811

If you fail to submit a timely request for administrative review, the Department of Health and Welfare's decision to issue the provisional license becomes final. Please note that issues, which are not raised at an administrative review, may not be later raised at higher level hearings (IDAPA 16.05.03.301).

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in the State Informal Dispute Resolution (IDR) Process which can be found on the Internet at:

www.icfmr.dhw.idaho.gov

Scroll down until the Program Information heading on the right side is visible and there are three IDR selections to choose from.

This request must be received by December 14, 2010. If a request for informal dispute resolution is received after December 14, 2010 the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

We urge you to begin correction immediately. If you have any questions regarding this letter or the enclosed reports, please contact me at (208)334-6626.

Sincerely,

M. Nielsen

MONICA NIELSEN
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MN/srm
Enclosures

12-15-10

Credible Allegation of Compliance
Plan of Correction

Bureau of Faculty Standards
3232 Elder St.
Boise, ID 83720

RE: Milestone Decisions, Inc. #1 Provider #13G016

Dear Survey Team,

This is out Credible Allegation of Compliance Plan of Correction for the Milestone Decisions, Inc. #1 Provider #13G016. We will be in compliance with the Condition of Participation on Client Behavior and Facility Practices (42CFR483.450) on December 22, 2010. Please refer to the following plan of correction which outlines how the correction of each deficiency will be achieved

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G016	A. BUILDING _____ B. WING _____	11/18/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILESTONE DECISIONS INC #1 GRANT	922 N GRANT ST MOSCOW, ID 83843

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM177	16.03.11.075.09 Protection from Abuse and Restraint Protection from Abuse and Unwarranted Restraints. Each resident admitted to the facility must be protected from mental and physical abuse, and free from chemical and physical restraints except when authorized in writing by a physician for a specified period of time, or when necessary in an emergency to protect the resident from injury to himself or to others (See also Subsection 075.10). This Rule is not met as evidenced by: Refer to W154.	MM177	Refer to Plan of Correction	
MM191	16.03.11.075.09(c) Last Resort Physical restraints must not be used to limit resident mobility for the convenience of staff, and must comply with life safety requirements. If a resident's behavior is such that it will result in injury to himself or others and any form of physical restraint is utilized, it must be in conjunction with a treatment procedure designed to modify the behavioral problems for which the patient is restrained and, as a last resort, after failure of attempted therapy. This Rule is not met as evidenced by: Refer to W313.	MM191		
MM192	16.03.11.075.09 (d) Drugs Drugs such as tranquilizers must not be used as chemical restraints to limit or control resident behavior for convenience of staff. This Rule is not met as evidenced by:	MM192		

Bureau of Facility Standards

Cliff McAleer — Administrator — 12-15-10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G016	A. BUILDING _____ B. WING _____	11/18/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILESTONE DECISIONS INC #1 GRANT	922 N GRANT ST MOSCOW, ID 83843

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS The following deficiencies were cited during the annual recertification survey. The survey was conducted by: Monica Nielsen, QMRP, Team Leader Trish O'Hara, RN Michael Case, LSW, QMRP Common abbreviations/symbols used in this report are: ADHD - Attention Deficit Hyperactivity Disorder CFA - Comprehensive Functional Assessment CPI - A physical restraint system IED - Intermittent Explosive Disorder IPP - Individual Program Plan PT - Physical Therapy QMRP - Qualified Mental Retardation Professional	W 000		
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on review of incident reports and staff interviews, it was determined the facility failed to ensure all injuries of unknown origin were thoroughly investigated for 1 of 2 individuals (Individual #3) for whom injuries of unknown origin were reported. This resulted in an investigation not being thorough. The findings include: Incident reports, dated 5/1/10 - 11/16/10, were reviewed and showed the following injury of unknown origin was not thoroughly investigated,	W 154	Refer to Plan of Correction	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Cliff McAlear Administrator 12-15-10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PLAN OF CORRECTION
#13G016.

W154

All incident/accident reports will be thoroughly investigated. This corrective action will be accomplished for those individuals found to have been affected by this practice and for all individuals in the home who have the potential to be affected. To ensure the deficient practice does not recur the House Administrator/QMRP and the Lead Worker will undergo training on thorough investigations. All investigations will be monitored by a review committee at the weekly Administrator/ QMRP meeting to ensure the deficient practice will not recur.

Completion Date: 1-20-11

W159- refer to W-214, W-227,W-237, W-239, W-242, W-260, W-278, W-289, W-313, W460.

W214

Behavior Assessments will be completed for those individuals found to have been affected by the deficient practice. Comprehensive Functional Assessments will be reviewed for all individuals at the home to determine if a behavioral assessment is needed. The Comprehensive Functional Assessment will be revised to identify those individuals in need of a behavioral assessment. In addition a new behavioral assessment has been created and will be completed for all individuals identified in the CFA to be in need of a behavioral assessment. A category for the behavioral assessment will be added to the IPP checklist, reviewed by the Administrator, to ensure the deficient practice will not recur.

Date Completed: 12-22-10

W227

Refer to W-214 as it related to meeting the behavioral needs individuals #1 and #2 and all individuals in the home having the potential to be affected by the deficient practice. 3. All assessments and recommendations, for the individuals affected by the deficient practice and all individuals in the home potentially affected, will be included in the CFA. A category will be added to the IPP checklist reviewed by the Administrator, to monitor that the deficient practice will not occur.

Date Completed: 12-22-10

W237

A new data collection system will be implemented for those individuals found to be affected by the deficient practice and for all individuals in the home potentially effected. The new data collection system will provide the additional information necessary to determine the efficiency of individuals behavior intervention strategies. The House Administrator/QMRP and the Lead Worker will monitor data collection by reviewing weekly.

Date completed: 12-22-10

W239

Replacement plans will be developed for all maladaptive behaviors identified in the behavior assessment (refer to W214) for the individuals found to have been affected by the deficient practice and for all individuals in the home who have the potential to be affected. The new behavior assessments is structured to ensure each identified maladaptive behavior has a corresponding replacement behavior. This will be monitored on the IPP checklist which will list maladaptive behaviors and replacement plans.

Completed by: Dec 22, 2010

W-242

The CFA's will be reviewed for the individuals found to be affected by the deficient practice and for other individuals in the home having the potential to be affected. This will ensure training in personal skills essential for privacy and independence, for those who lack them, will be included in their IPP. During review, a checklist of the personal skills outlined in W-242 will be completed and compared to IPP to ensure the deficient practice will not recur. The personal skills list will be added to the IPP checklist, which will be reviewed by the Administrator, to monitor and to ensure the deficient practice will not recur.

Completed by: Feb 1, 2011.

W260

All IPP's will be compared with assessments and training plans to ensure accuracy and consistency for those individuals found to have been affected by the deficient practice and for all other individuals in the home who have the potential to be affected. Refer to W 227 as it relates to assessments and recommendations being incorporated into the CFA. Also, refer to W 242. A list of the individuals current needs as identified in the CFA will be generated and matched to the IPP. The list will become part of the IPP checklist for monitoring processes.

Completion Date: 2-1-11

W 266- refer to W214, W227, W237, W239, W276, W278, W289, W313

W276-

The door alarms have been removed from the facility. This affects all the individuals in the home. All faculty approved interventions to manage inappropriate behavior will be specified on the policy governing the management of inappropriate client behavior. All restrictive interventions will be compared to the behavior policy to ensure the defiant practice does not recur. This will be monitored by an annual review of restrictive interventions on the IPP checklist by the Administator.

Date completed: 12-22-10

W278

Policy and procedure governing the management of inappropriate client behavior will be revised to ensure individuals records include evidence of least restrictive or more positive

techniques being utilized prior to the use of more restrictive techniques. This will be accomplished for those individuals found to have been affected by the deficiency as well as other individuals having the potential to be affected by the same deficient practice. Staff will be trained on the new policy and evidence of the least restrictive or more positive techniques will be documented in WIC. This will be monitored by HRC and treatment upon review of behavior programs.

Date completed:12-22-10

W289

Behavior programs will be reviewed and revised to ensure techniques used to manage inappropriate behavior are sufficiently defined and incorporated into the program plans. This will be utilized for those individuals found to have been affected by the deficient practice as well as all individuals in the home who are potentially affected. Additional professional training, by a contract behavior specialist for all QMRP's, on behavior programs writing and implementation will be provided. Treatment team and HRC will monitor through review and approval of behavior programs.

Date Completed: 12-22-10

W313

For the individual found to have been affected by the deficient practice, the facility will do a record review to determine if the harmful effects of the behavior outweigh the associated risks of the drugs. The treatment team will meet to assess the documentation and agree on a course of action. In addition this individual has received an evaluation from St. Joes Psychiatric Unit which the team will be reviewing and considering as well. For all other individuals having the potential to be affected by the defiant practice a record review will be conducted and a treatment team assessment will take place. Refer to W 214, W 237 and W 278 as new measures put place and support the teams decision. This will be monitored by review at HRC meeting.

Date Completed: 12-22-10

W381

For all individuals in the facility all controlled drugs are currently stored under a double lock system. Staff have been retrained on the facility procedure to ensure all controlled drugs are stored under a double lock system. The med checker will check the locks to ensure compliance and initial on med checker sheet. House Administrator/QMRP and Lead Worker will monitor by reviewing checklist regularly.

Date Completed: 12-22-10

W382

For all individuals in the facility all drugs and biologicals are currently kept locked except when being prepared for administration staff have been retrained in the facility procedure to ensure all drugs and biologicals are kept locked. The med checker will check the lock after med pass to ensure compliance and initial on med checker sheet. House Administrator/ QMRP will monitor by reviewing checklist regularly.

Date Completed: 12-22-10

W426

Water temps are currently maintained at or below 110 degrees Fahrenheit. To ensure the deficient practice does not recur staff will take water temperatures daily, record the temperatures on a daily log and will be instructed to notify a supervisor when they have a reading higher than 110. House Administrator/QMRP and Lead Worker will monitor by reviewing of temp logs on a regular basis.

Date completed:12-22-10

W460

The facility will ensure the meal plans for the individuals found to have been affected by the deficient practice and the meal plans for all other individuals in the home will be followed. Staff will receive training on the proper implantations and documentation of meal plans. House Administrator/QMRP will monitor by reviewing nutritional data and regular observation.

Date Completed: 1-15-11

MM 177–Refer to W154

MM 191–Refer to W313

MM 192–Refer to W313

MM 193–Refer to W278

MM 197–Refer to W289

MM 212–Refer to W 242 and W266

MM 271

All toxic chemicals are labeled and stored under lock and key. This affects all individuals in the home. To ensure this deficient practice does not recur the keys are now kept in an area not accessible to the individuals residing in the home and staff have been instructed on the new policy. House Administrator/QMRP will monitor by regular check on the locked closet.

Date completed: 12-15-10

MM 412

Repairs or replacement of all noted items have been scheduled. An inspection of the entire environment has been scheduled with the maintenance Dept. to determine if there are any other repairs necessary. Maintenance will do a monthly inspection to ensure the environment is in good repair. House Administrator/QMRP will monitor by reviewing checklist and scheduling repairs.

Date completed: 2-01-11

MM 520- Refer to W 276

MM 647- Refer to W 460

MM 725 - Refer to W 159

MM 729- Refer to W 227

MM 730- Refer to W 214

MM 731- Refer to W 237

MM 753- Refer to W 381 and 382

MM 812- Refer to W 239

MM 861- Refer to W 260